COMPREHENSIVE CHILD MENTAL HEALTH PLAN

Introduction and Overview

The provision of mental health services to children and adolescents is a major component of the mission of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Over the years, the way in which the Division carries out that aspect of its mission has been influenced, positively and negatively, by a number of factors such as Carolina Alternatives, "Willie M.", Comprehensive Treatment Services Program (CTSP), Systems of Care, and out-of-home placements, among others. While remnants of these various issues continue to influence how services are provided, there is no coherent philosophy that guides the provision of services to children. As the Division proceeds with mental health reform, we are presented with an opportunity for a fundamental re-examination and overhaul of our approach to service delivery to children and their families.

This plan seeks to take advantage of the opportunity by developing a system that relies upon evidence and partnerships with families as the basis for service provision. The current system is based on services and funding mechanisms that are not always supported by available research and do not always encourage partnerships. Families will be respected and included as partners in the treatment process and collaboration among child serving agencies will be encouraged and supported. The new design will utilize evidence-based practice to achieve the outcomes families want. North Carolina has laid the groundwork for state and local collaboration through the State Collaborative for Children's Services. Through this plan we will build the infrastructure to support and maintain these collaborative efforts.

The purpose of this plan is to provide a framework to address structural, financing, and organizational issues encountered in serving children with mental health disorders and their families. This plan addresses services for all children who receive publicly funded mental health services, including those who are in residence at state facilities and in other out-of-home placements. The intent of this plan is to foster the development of a full range of formal and informal services and supports in communities across the state. The thrust of the plan is to support families in ways that minimize the need for out of home placements.

Planning Process

Nationally, school systems, juvenile justice systems, social services, the medical community and the mental health, substance abuse and developmental disabilities service systems are grappling with ways to serve children with complex, multiple needs with limited, dwindling resources. This is providing the impetus for states to re-evaluate traditional methods of service delivery in which agencies provide services and funding via "silos". Instead, states are engaging in planning efforts in which agencies collaboratively plan to implement systems of care for children with serious emotional disorders (SED) and their families. In this planning process, the Division recognized the importance of building upon the existing foundation of systems of care in North Carolina; therefore, a planning structure was designed utilizing members of the North Carolina State Collaborative for Children's Services to develop recommendations for a comprehensive children's services plan. The State Collaborative, which has been in

existence for over two years, consists of representatives from juvenile justice, social services, public health, Division of Medical Assistance, area mental health programs, child residential facilities, state psychiatric hospitals, universities, advocacy groups and parents of children with serious emotional disturbance. This group has played a key part in increasing inter-agency collaboration and reducing barriers in serving children with mental health needs.

Initial planning began with the State Collaborative during the third week of April and continued with six day-long meetings through June 17, 2003. The Collaborative was provided fact sheets summarizing characteristics of the population, models for approaching systems planning and research on evidence based practice prior to the first meeting. An external consultant to the Division facilitated the meetings. A Division team added the final specifications and action steps to the work of the State Collaborative.

This approach resulted in the following key components of this plan:
- Mission, Vision and Guiding Principles
- Iteration of Critical Success Factors
- The Collaboration Necessary to Support the Development of Key Child Developmental Assets
- Recommendations for a Comprehensive Array of Services and Supports
- An Agreement to Decrease Reliance on Restrictive Care Through Service Priorities for Downsizing
- Recommendations for Training Needs Relative to the Service Array
- Prioritization of Outcomes
- The Role of the Collaborative and Families in Monitoring Outcomes
- Recommendations for Communication About the Draft and Final Plan
- An Operational Plan

This resulting child mental health plan supports the foundation of reform by giving children and families a voice and focusing on collaborative and flexible supports delivered within the life environment of the child. The plan also addresses the issues and recommendations of the Report of the Surgeon General on Mental Health including building the science basis for treatment, overcoming stigma, improving public awareness of effective treatment, ensuring a qualified supply of providers, using evidence-based interventions, addressing cultural issues, improving access, and tailoring available resources to reduce barriers to effectiveness. The components of this plan mirror and support the studies mandated by the North Carolina General Assembly in 1995 and 1999, and recommendations in House Bill 1519 and Senate Bill 381. The essential recommendations, which bridge the Surgeon General's Report and previously commissioned studies, include increasing community capacity, decreasing reliance on state operated services, establishing local accountability, establishing "bridge" funding, ensuring consistency and standardization of services state-wide and focusing on the primary consumer through child and family centered plans for supports and services.

Defining the Discussion: Characteristics and Current Data

Children Served

While there are several studies that provide estimates of the prevalence of mental health disorders among children - ranging from 28 to 20 percent for mild mental health disorders and 5 to 6 percent for serious emotional disorders- North Carolina estimates 10 to 12 percent of the state's children experience serious emotional disturbance (SED).

This is based on the prevalence rate cited in the Federal Register, June 1998. The NC Office of State Budget and Management estimates that there are 1,964,047 children in North Carolina under age 18 based on U.S. 2000 census data; therefore, the estimated number of children under the age of 18 with SED is between 196,404 and 235,686.

Not all children with SED receive services through Local Management Entities (AP/LMEs). According to the Great Smoky Mountain Study, an epidemiological study conducted by Burns and colleagues on a North Carolina population of children and their families, 89 percent of children seek mental health services from their primary care provider. The number of children who access AP/LME services reflect that a large number of children with serious emotional disturbance are either seeking private sector services or are unserved. The following table provides a five-year analysis of the number of children with a primary mental health diagnosis who access community-based, residential and inpatient psychiatric services through the AP/LMEs. Of the estimated 235,686 children with SED, 85,703 children served during State Fiscal Year 2001-2002 accessed services through an AP/LME.

Total Number of Children and Adolescents with a Mental Health Diagnosis Served by Area Mental Health Programs

Year	Number Served
SFY98	76,485
SFY99	78,185
SFY00	64,698
SFY01	74,723
SFY02	85,703

As indicated in State Plan 2003: BluePrint for Change, it is the intent for AP/LMEs to provide basic mental health services to all children seeking care while providing an enhanced array of services to targeted populations. This plan addresses the service, financing and organizational needs for all child mental health target populations. Following are criteria for the four target population groups for children with mental health needs.

Child with serious emotional disturbance who requires out-of-home placement (CMSED)

Child, under the age of 18, with atypical development (up to age 5) or serious emotional disturbance (SED) as evidenced by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.AND
Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as indicated by one or more of the following:

- CAFAS score of at least 90; **OR**
- Total CAFAS score is greater than or equal to 70 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning; **OR**
- In need of specialized services from more than one child-serving agency (e.g. mental health provider(s) and DSS, DPI/schools, DJJDP, DPH, DCD or health care).

AND

Placed out of the home or at risk of out-of-home placement, as evidenced by any of the following:

- Utilizing or having utilized acute crisis intervention services or intensive wraparound services in order to maintain community placement within the past year.
- Having had three or more psychiatric hospitalizations or at least one hospitalization of 60 continuous days within the past year.
- Having had DSS substantiated abuse, neglect or dependency within the past year.
- Having been expelled from two or more daycare or pre-kindergarten situations within the past year.
- Having been adjudicated or convicted of a felony or two or more Class A1 misdemeanors in juvenile or adult court or placed in a youth development center, prison, juvenile detention center or jail within the past year.
- Situation exacerbated by special needs (e.g. physical disability that substantially interferes with functioning).

Child with serious emotional disturbance (CMMED)
Child, under the age of 18, with atypical development (up to age five) or serious emotional disturbance (SED) by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9;

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as evidenced by one or more of the following:

- CAFAS score of at least 60; **OR**
- Total CAFAS score greater than or equal to 40 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

Child who is deaf or hard of hearing (CMDEF)
Child, under the age of 18, who is assessed as deaf or as needing specialized mental health services due to social, linguistic or cultural needs associated with individual or familial deafness or hearing loss;
AND
The presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.
NOTES: Deaf children will be dually enrolled as both Deaf/HH and in their appropriate population category, or order to receive a full array of services. Where this funding is available, it will be depleted before other funding sources pay for the eligible service.

Child who is homeless – PATH (CMPAT)
Child, under the age of 18, who has serious emotional disturbance (SED) and has an ICD-9 diagnosis(es) and is;

Homeless, as defined by:

- Lacks a fixed, regular, adequate night-time residence; **OR**
- Has a primary night-time residence that is:
  (a) Temporary shelter; **or**
  (b) Temporary residence for individuals who would otherwise be institutionalized; **or**
  (c) Place not designed/used as a regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

- Due to be evicted or discharged from a stay of 30 days or less from a treatment facility
  AND
- Who lacks resources to obtain and/or maintain housing.

Where Services are Provided
Currently, mental health services for children are provided in a variety of settings; however, over the past several years there has been an increase in the reliance on facility-based services and restrictive types of care including state psychiatric hospitals, Psychiatric Residential Treatment Facilities (PRTFs), state residential treatment centers and other residential treatment facilities.

During SFY03, the four state hospitals collectively had 1,310 admissions to their child and adolescent units. The average daily census for the four hospitals was 83. Current plans call for a reduction in the number of child and adolescent beds in the state hospitals to 55 by SFY06 and for the elimination of PRTFs in the state hospitals by SFY05.

The PRTF was added to the continuum of Medicaid-covered services effective October 2000. There are approximately 18 providers that offer PRTF care, including two state psychiatric hospitals. For SFY02, there were 333 children served in PRTFs at a cost of $12.4 million in Medicaid dollars. Complete data are not yet available for SFY 03.

There are currently three state residential treatment centers for children and adolescents: Whitaker School, Wright School and the Eastern Adolescent Treatment Program (EATP). Whitaker School is a 36-bed facility that serves adolescents, ages 13-17. The North Carolina General Assembly has endorsed plans that call for the closure of Whitaker School. Wright School is a 24-bed facility and EATP is an 8-bed facility. Upon effective implementation of the community-based services envisioned in the child mental health plan, it is anticipated that this would lead to the eventual closure of Wright School and EATP.

Due to changes in residential provider rates and the provider enrollment process, additional community-based residential providers were established in North Carolina during SFY01 through SFY03. The chart below provides the number of facilities licensed by the Division of Medical Assistance and number of beds available in North Carolina as of November 2002. The total number of residential providers rose from 148 in August of 2001 to the present number of 400. The total number of residential beds available has increased from 1072 in August 2001 to the present number of 2,248.

Residential Childcare Provider Log- November 02

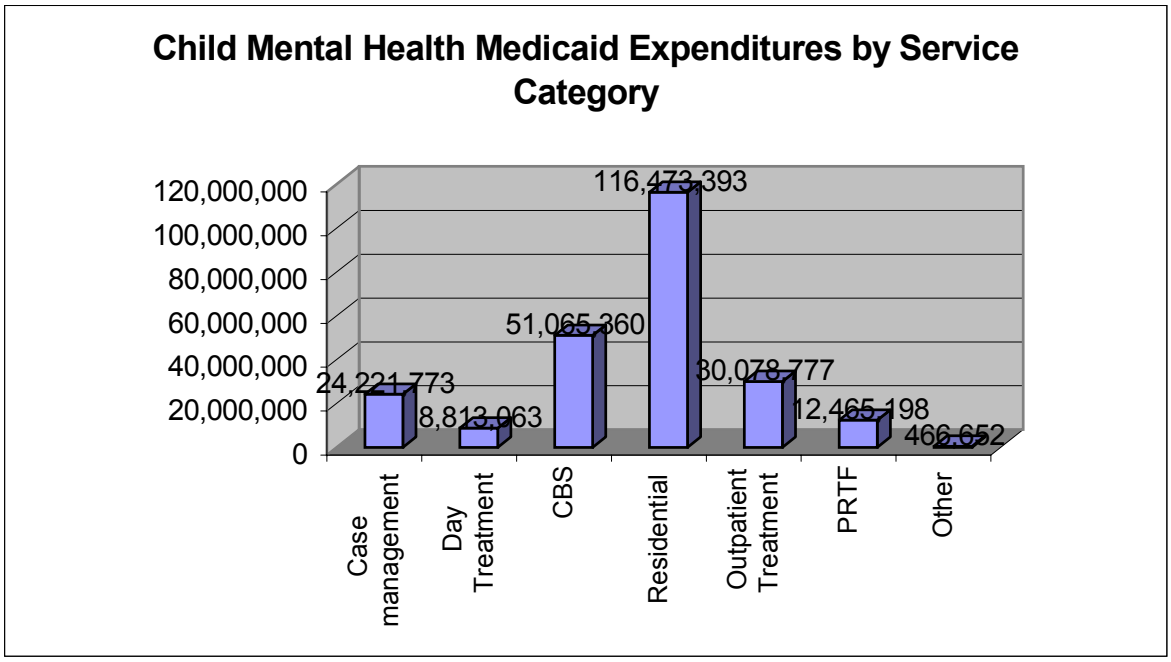
	Level II	**Level II & III**	**Level III**	**Level III & IV**	**Level IV**	**Total**
Number of Facilities	18	52	325	3	2	400
Number of Beds	186	423	1,592	14	33	2,248

Cost of Services Provided

Child mental health services are funded via Medicaid, state and federal funds. For SFY02, there was a total of $69,348,209 in state and federal funds available to support community –based services. State dollars supporting state treatment facilities, including Whitaker School, EATP and Wright School totaled $8,597,761.

Additionally, Medicaid was billed for over $247 million for child mental health services for SFY02. An analysis of Medicaid billing shows that a large percentage of available resources are supporting child residential treatment Levels II-IV. In SFY02 49% ($166 million) of the total child mental health Medicaid expenditures were for residential treatment. These services were provided to 9% (3,485) of the children utilizing mental health services.

The following chart provides a breakdown of Medicaid expenditures for SFY02 by service category presenting a picture of the high cost of child residential treatment. These figures include AP/LME billed services as well as direct-billed services.



Current System Capacity Concerns

While there appear to be considerable resources available in the child mental health system, there are several mechanisms that prevent access to high quality community-based services that reflect best practices.

- There is currently limited capacity for in-home services. While research indicates that in-home services such as home-based, wraparound and multisystemic therapy promote family preservation and have positive outcomes for children with SED and their families, the current mental health system does not provide funding mechanisms, treatment protocols or training to support these services.

Historically, some programs have been supported though grants from the Division of Social Services (DSS) and the Department of Juvenile Justice and Delinquency Prevention (DJJDP); however, this funding is being eliminated and these services can not be solely supported through Medicaid receipts.

- There is a lack of child psychiatrists statewide. A 1999 Needs Assessment of Mental Health Programs prepared by the Area Health Education Centers Program, showed that 51% of Area Mental Health Programs indicated a high priority need for additional child psychiatrists.

- Crisis management and response is inadequate. Findings from the Carolina Alternatives program indicated a need for better crisis response at home and school, a need for in-home up to 24 hour support. Also, crisis management was the worst indicator in the study of NC Families and Children Equal Success (FACES) – a Center for Mental Health Services System of Care demonstration grant site.

- Communities are relying heavily on state psychiatric hospitals and residential placements for the provision of care. Community psychiatrists in North Carolina are emphasizing the use of state psychiatric hospitals due to lack of adequate psychiatric services for children in community hospitals.

- There are inadequate community resources to enable children to receive a quality assessment before services are initiated.

Planning Framework

The framework for developing the Child Mental Health Plan was created by the North Carolina Statewide Children's Collaborative in response to an invitation from the Division. The Collaborative acknowledges the characteristics and needs of children with Serious Emotional Disorders (SED) and the experiences they and their families have while seeking services within the traditional structures of child serving agencies. Multiple child serving agencies, such as mental health, public health, social services, juvenile justice and public schools are responsible for meeting various service needs of these children and families. These service agencies often have separate organizational boundaries and overlapping or conflicting mandates. Families become overwhelmed by the multiple intake procedures, rules and criteria, and sometimes conflicting service plans formulated by different agencies. In addition, traditional agencies tend to rely on professional "expert" assumptions about what children and families should receive rather than responding to what they request. The Collaborative examined these issues and the desire of the State to create a community based service array that would support a reduced reliance on state hospitals and other levels of residential care.

The following constitutes the framework for the Child Mental Health Plan as established by the Division in collaboration with the State Collaborative, AP/LME and state institution partners. The mission, vision and guiding principles are consistent with the State Plan 2003 and are based on well-researched programming efforts espoused by the Center for Mental Health Services and the United States Surgeon General's Report on Mental Health Services.

Mission

North Carolina will provide children and families with mental health needs a system of quality care, which includes accessible, culturally appropriate, individualized mental health treatment, intervention and prevention services delivered in the home and community in the least restrictive and most consistent manner possible.

Vision

Families, professionals and communities join hands to enable children to be happy, healthy and successful by providing a seamless system of care.

Guiding Principles

1. Families are partners in all aspects of planning, policy, decision-making, service delivery, and evaluation at the state and local level.

2. Families are provided education and support, including peer support, in order to facilitate their partnership role.

3. The system and services are driven by the child and family and their needs and preferences rather than funding.

4. Collaboration is the cornerstone of the system and occurs among the AP/LME, all child-serving agencies, all network providers, family members and other community stakeholders.

5. The system is accessible as evidenced by a comprehensive array of services that are available in a timely manner in geographically convenient locations.

6. The system's quality improvement process is embedded throughout, and includes a focus on functional outcomes, clear standards, accountability measures for AP/LMEs and providers, and inclusion of family members in the quality improvement and monitoring process.

7. The child is conceptualized in a holistic manner. Health, educational, social, recreational and vocational needs are considered along with mental health needs.

8. Education and training occur at multiple levels to achieve a competent fully functioning system.

9. Adequate, flexible resources for all services are available so that funding does not drive the child and family plan.

10. Informal services and natural supports are emphasized.

11. Cultural values of families and community norms are honored.

12. A minimum set of services is required across the state and in communities to insure consistency and predictability.

13. Children and their families have access to quality services based on best practice models and evidence-based treatment methods provided by qualified caregivers.

14. The system promotes continuity of services for children as they transition between providers or move into adult services.

15. Prevention and early intervention services are emphasized.

16. Familial bonds are respected and protected. Families should not have to give up custody of their children in order to obtain appropriate services.

Critical Success Factors

Critical success factors are key strategies that, when achieved, propel the system toward attainment of its vision. Each factor is of equal importance and all factors must be focused on simultaneously to be effective. These factors form the basis for the Division's specification of action goals in the Division's Operational Plan. Seven factors must be attended to in order to achieve positive change in the child mental health system.

RESOURCES:
- Maintain existing funding while shifting the use of those funds away from restrictive modes of care.
- Create a flexible pool of funds to be utilized locally for Child and Family Plans.
- Informal, community and natural supports are accessed before using or simultaneously with the use of public services.
- Communities develop directories and means for accessing community and natural supports.
- Communities coordinate existing resources and services including early intervention services.

COMMUNICATION:
- Marketing, education and training of families in rights and responsibilities must be done at the local level.
- Early intervention and prevention activities should be funded and promoted.
- Public Health education includes mental health and parenting education.
- The Legislature, general public, local officials and key agency staff must be educated to understand the child mental health plan.

PARTNERSHIP WITH STAKEHOLDERS:
- Involve the state and local Collaboratives in Continuous Quality Improvement (CQI) efforts with at least 50 percent of participants as families.
- Provide training and supports for families to participate in a meaningful way.
- Create other mechanisms for families and other stakeholders to be involved in monitoring outcomes.
- Train other stakeholders in the plan.
- Encourage community capacity building such as neighborhood resource centers, parent skills training carried out in variety of locations (particularly schools), expand community safety nets, address transportation issues, and provide conflict resolution training.

- Work with physicians to provide training and consultation on child psychiatric/medication issues.
- Work with communities to help each child have a medical home.

BEST PRACTICES:
- Define a minimum required statewide set of services with written standards.
- Implement and monitor a policy for least restrictive care.
- Adopt best practices that include cultural competencies.
- Conceptualize children holistically.
- Consider family, community and cultural values in establishing the service array.
- Provide training to the AP/LME, providers and families.
- Recruit competent and qualified providers.
- Create policy and criteria for development of the Child and Family Plan.

ACCESS:
- Establish convenient locations and monitor timeliness standards.
- Create one screening application to be used by all agencies.
- Make the array of services available statewide.
- Establish gate keeping for entry to restrictive care.
- There is a set of required minimum services for consistency statewide.
- There is specialist availability to assess target populations with high needs.
- There is outreach to schools, courts and children in foster care.

ACCOUNTABILITY:
- Establish outcome measures and benchmarks.
- Functional outcomes are designed with input from stakeholders.
- Establish process for collecting evaluation data.
- Clarify CQI expectations in contracts and MOAs.

MEMORANDA OF AGREEMENT:
- State Divisions, Departments set policy for collaboration and boundaries.
- All state contracts and MOAs include the requirement for Collaboratives.
- Local Collaboratives develop agreements within communities.
- Statewide training is provided in development of agreements at the local level.
- All agreements must minimally include continuity of service agreements, no eject/no reject agreements, families as partners, parental support mechanisms, and who pays for the service.

Summary of Agency Responsibility to Support Developmental Assets

While responsibility cannot be assigned to other agencies through this plan, there is clear agreement as to the importance of the support of the entire community and its public agencies in assuring the development of assets that ultimately create a healthy, responsible adult capable of giving back to a community. Those developmental assets include for children birth to five years old:
- A Safe Home
- A Loving Caregiver
- A Stimulating Environment
- Healthy Beginnings And Development
- School Readiness By Age 5

Developmental assets for children and youth age 6-18 include:

- A Safe Home
- Caring Adults
- School Success
- Positive Peer Relationships
- Healthy Behaviors
- Opportunities To Give Back

To accomplish these objectives, the involved agencies agreed in principle to collaboratively and jointly support the following efforts within their available resources and usual work roles.

- Provide early identification and assessment incorporating use of screening tools for newborns.
- Provide access to services through one application to an array of services.
- Provide outreach to schools, police, and families involved with other agencies as well as home visiting programs.
- Provide early intervention that incorporates developmental education, parenting training and a mental health screening in a variety of settings.
- Identify and support a strong adult role model for every child.
- Support family partnerships with agencies.
- Build community capacity for families to care for each other.
- Coordinate existing early childhood programs.
- Provide agency and peer supports for parents so that they can maintain the adult role in the family.
- Seek safe, affordable stimulating childcare with subsides, as necessary.
- Provide resources with physical, web-based information and referral to a wide variety of services and supports.
- Aid families in obtaining needed resources to meet their basic needs.
- Provide education and work skills training for parents.
- Provide children multiple paths to success, including vocational education.
- Support the expansion of and greater availability of supervised after school activities.
- Partner with families and Mental Health to identify children at risk earlier.
- Collaborate to avoid children being ejected or dropping out of school settings.
- Make available primary family health and wellness education.
- Be proactive in community planning for children and families.
- Teach and encourage adult caregivers to practice healthy behaviors and assume caring adult roles and responsibilities.
- Encourage families to participate in treatment and actively use supports and resources.
- Involve families in policy making and planning for effective services for children.
- Promote “problem solving courts” where judges are trained to demand effective integrated services for children and families.
- Develop safe, affordable housing.
- Expand community safety nets through community watches.
- Provide reliable, safe and affordable transportation to access care.
- Develop community/neighborhood centers with family supports.
- Identify community resources to support families.
- Provide a safe place for children to learn developmentally appropriate behaviors through a variety of activities and choices.
- Provide social educational, recreation and vocational activities to teach responsibility, leadership and the ability to work together.

- Provide opportunities for peer interaction.
- Engage in proactive community planning to address child and family needs.
- Support accessible, affordable medical care.
- Advocate for more funding for Medicaid and HealthChoice to ensure a medical home[1] for each child and their parents.
- Increase access to health care- primary, dental, vision screening.
- Provide conflict resolution and social skills training for children and youth in collaboration with other agencies.
- Encourage and support males as caregivers.
- Sponsor legislation to support/mandate sharing and agreements between agencies, if necessary.
- Educate decision makers regarding child mental health needs and systems of care.

ENVISIONED SERVICE ARRAY

As delineated in the State Plan 2003, AP/LMEs will have responsibility for authorizing a plan of services to meet the needs of the child and family. This plan stresses the importance of AP/LME following best practice protocols in providing services and supports.

Assessment and Diagnosis

Assessment and Diagnosis

Description:

Generally accepted professional assessments or tests, including psychological tests or specialized outpatient assessments that are conducted for the purposes of determining level of functioning and treatment needs of the individual. Specialized outpatient assessments may include sex offender specific evaluations, forensic, substance abuse, and sexual abuse/trauma evaluations. These also include psychosocial, developmental, and vocational assessments.

Appropriate for:

- Children with suspected or established emotional disorders that are seeking services from the AP/LME.
- Specific assessments are determined based on age, cognitive presentation, symptom presentation and the specific service to which the child is seeking admission.

Amount and Duration:

- Assessments are authorized annually or when there is a significant change in condition. A child may need more than one assessment to establish strengths and issues for child and family planning. The specific reason for the assessment is required.
- Assessments more than one year old require documentation of suspected changes in condition.

Psychological Testing

[1] A medical home is defined by the National Center of Medical Home Initiatives for Children with Special Needs as child medical care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

Description:
Standardized intelligence, personality, or neuropsychological tests rendered by licensed psychologists. The child's clinical record must indicate the name of the person who administered the tests, and the actual tests administered. The protocols for testing must be available for review. Best practices indicate that projective testing or personality testing is not generally useful for children with the exception of the Thematic Apperception Test (TAT) or the House-Tree-Person. IQ testing is required to document a developmental disability and is generally provided through the school system. Neuropsychological testing is utilized when there is a compelling reason to test for an Acquired Brain Injury (recent onset), a recent Traumatic Brain Injury wherein assistance may be prescribed specific to new deficits, or suspected cognitive deficits due to abuse, substance abuse, or genetic causes wherein the results may lead to child and family planning for better outcomes.
Appropriate for:
- Child who is not responding to recommended treatment and/or diagnosis is in doubt.
- Child who is age 17 or younger, with a suspected ADHD diagnosis, referred for psychotropic medications.
- Child for whom guardianship has been requested.
- Child who is experiencing a deterioration of cognitive function with suspicion of a recently acquired or traumatic brain injury.

Amount and Duration
- One time only per test.

Psychiatric Evaluation
Description:
A comprehensive evaluation, performed face-to-face by a psychiatrist, that investigates a child's clinical status including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination. This examination concludes with a written summary of positive findings, a bio-psychosocial formulation and diagnostic statement, an estimate of risk factors, initial treatment recommendations, estimate of length of stay when indicated, and criteria for discharge.
Appropriate for:
- Child with a suspected diagnosis of an emotional and/or behavioral disorder and community resources or a community-based physician cannot meet consumer need.
- Child who is not currently able to use community based physician to provide stabilizing medication regimen.

Amount and Duration:
- An annual evaluation.

Psychiatric Medication Review
Description:
This service includes evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. The medication review may result in the prescription of medications including the assessment of current prescribed medications for safety and efficacy and the coordination of medication orders among all involved providers. The service includes an assessment of the medication's desired effect; current orders evaluated in all

care settings; and coordination between the physicians, pharmacy, and care settings.

Appropriate for:

- Child who is diagnosed with a serious emotional disorder for which medication is an effective treatment per accepted standards of practice.
- Child's medication oversight cannot be met by community resources.
- Children must have a primary clinician unless the following criteria are met for "meds only".
  - Crisis-free for 1 year.
  - Compliant with physician appointments.
  - Compliant with primary mental health provider appointments.
  - Stable on current medications for at least 6 months.
  - Child and Family Planning Team agrees with a transfer to community physician.

Also, appropriate when:

- Physician does not feel comfortable supervising the administration of medication prescribed by a community physician.

Amount and Duration:

- Authorized at least quarterly for physician's medication review.

Community Inpatient and Inpatient Alternatives

Community Inpatient and Inpatient Alternatives

Description:

Local or state inpatient psychiatric services are designed for children experiencing an acute psychiatric crisis. Screening services include determining whether inpatient or alternative services are the most appropriate. Screening services are provided face to face. Screening is provided in a manner that maximizes consumer involvement and engagement. This includes conducting inpatient screening in community settings. .Screening shall assure that children are provided least restrictive treatment and diverted to inpatient alternatives when clinically appropriate. This service is available at all times (24 hours a day/7 days a week). Service in the inpatient setting includes a comprehensive array of services provided to adequately treat acute psychiatric illnesses, including, psychiatric evaluation, enhanced health services, medication stabilization, and discharge planning through child and family planning teams. It is short term, and the goal is to stabilize the child and return the child to community supports and home as soon as possible.

Appropriate for:

- Child who is a danger to self and/or others or unable to care for basic needs due to SED. This may be exemplified by one of the following:
  - Child is not appropriate for less restrictive service due to safety concerns.
  - Child needs 24 hour supervision and less restrictive settings have been attempted or found ineffective at resolving/managing the acute symptoms.
  - Child needs a locked setting to ensure safety.
  - Functioning has decompensated, consumer/family does not recognize need for mental health treatment, and there is risk for further serious health safety risks.

- Child who has been placed on a combination of medications that cannot be safely titrated in the home or an alternative setting, even with the use of in-home nursing and monitoring.

Amount and Duration:

- Less than 2 weeks.
- Less restrictive services/inpatient alternatives may be authorized to shorten the length of stay.

Specialized Diagnostic Evaluation Unit
(10 beds statewide for ages 12 and under)
(10 beds statewide for ages 13-17)
Description:
Structured inpatient alternative treatment and support activities provided by a mental health team and designed to provide short-term, intermediate or complex diagnostic and assessment service that cannot be performed without 24-hour supervision. This may include assessments, stabilization on medication, and the initiation of a behavioral plan. Services are intensive treatment interventions delivered by an intensive assessment and stabilization treatment team, under psychiatric supervision. Service components include: intensive trauma therapy; assessments rendered by the treatment team including the psychiatric assessment; behavioral assessment and other testing; family support and planning; psychiatric supervision and medication review; and nursing services/consultation. A written plan must be in place that addresses medication issues and health and safety needs; specifies supervisory needs; includes training for the family in implementing the behavioral plan in the home; and includes discharge planning.
Appropriate for:

- Child age 17 and under with SED.
- Child who has multiple impairments, co-morbid conditions that are not commonly seen or easily treated with typical combinations of psychotropics and/or therapeutic interventions.
- Child requiring short-term and thorough specialist evaluation, medication stabilization and supervision to remain safe from self-harm.
- Child who can benefit from short term, intensive treatment and specialist evaluation to allow for the development, training of caregivers/family, and implementation of a home/community management plan.
- Child who is medically stable. A written review by a registered nurse is required prior to admission. Vital signs must be evaluated and must be within normal limits, as well as, major medical history conditions such as a cardiac condition, history of head trauma, substance abuse, diabetes, etc.

Amount and Duration:

- Short-term (2 weeks).
- Intermediate (4 to 8 weeks).
- Complex (3-4 months) with possible extension of up to 4 months when home trials of the management plan have failed.

Crisis Residential/Residential Treatment Center
Description:
Inpatient alternatives of intensive therapeutic services that provide short-term care for children experiencing an acute psychiatric crisis. Services are intended to avert a psychiatric admission, or to shorten the length of an inpatient stay and are designed for a subset of children who meet psychiatric inpatient admission

criteria or are at risk of admission, but who can be appropriately serviced in a setting less intensive than a hospital.

Appropriate for:

- Child requiring continued 24-hour supervision to avoid inpatient stay or to shorten the length of an inpatient stay as a result of a serious emotional disorder.
- Child requiring short-term medication stabilization and/or supervision to remain safe from self-harm.
- Child requiring 24-hour supervision to maintain safety needs.
- Child who is re-directable and can safely be supervised in an unlocked setting.
- Child who is medically stable. A written review by a registered nurse is required prior to admission. Vital signs must be evaluated and must be within normal limits, as well as, major medical history conditions such as a cardiac condition, recent history of head trauma, diabetes, etc.

Amount and Duration:

- A maximum of 14 days.

Community Living Services

Home-Based Services

Description:

Intensive therapeutic services to individuals and families with multiple service needs that require access to a comprehensive array of mental health services. Services are intended to promote normal development, promote healthy family functioning, support and preserve families, reunite families who have been separated, and reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings. The family unit is the focus of treatment, support and education. This is a bundled service that includes supervision, intervention, coaching and crisis management. This is a time limited intensive family preservation intervention intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for the identified youth. These services are delivered primarily to children in their family's home with a family focus to:

1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
2) ensure the linkage to needed community services and resources;
3) provide self help and living skills training for youth;
4) provide parenting skills training to help the family build strengths for coping with the child's disorder;
5) monitor and manage the presenting psychiatric and addiction symptoms; and
6) work with caregivers in the implementation of home-based behavioral supports.

Services may include crisis management, including in-home intensive case management and in-home crisis management, individual and/or family therapy, substance abuse intervention, domestic violence counseling services, parenting skills training, individual skills training, and other rehabilitative supports to prevent the need for a out of home, more restrictive services. This team approach is

structured face–to–face therapeutic interventions to provide support and guidance in all areas of functional domains including adaptive, communication, psychosocial, problem solving, and behavior management. This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength-based and focused on promoting youth and family stability, increasing the youth's and family's ability to cope and relate to others, and enhancing the highest level of functioning in the community.

Appropriate for :

- Child who has a diagnosis of SED **or** for Infant Mental Health (IMH), the parent must have a diagnosed mental illness or developmental disability **and** the family must have multiple risk factors as described below:
  - Child who has needs that require at least two contacts a week.
  - Child who is at risk for out of home placement (i.e., hospitalization, foster care) or is in an out of home placement and reunification is imminent.
  - Family needs intensive interventions to preserve family unit.
  - Child's behavior problems cannot be managed using Outpatient Services or Case Management.
  - Child has problems across settings (i.e., school and home functioning are both poor).
  - The child and/or family have insufficient or severely limited resources or strengths necessary to cope with an immediate crisis.
  - The youth and/or family issues are unmanageable in school based on behavioral program settings and require intensive coordinated clinical and positive behavioral interventions.
  - Repeated attempts at other less restrictive types of services have not been effective.

Amount and Duration:

- Services are provided in the family home and community.
- Documentation of the child's ongoing risk for out of home placement (i.e. hospital admissions, crisis assessments, utilization of crisis services, domestic violence, protective services involvement, etc.) is required.
- Documentation of the specific psychiatric symptoms and family issues to be addressed during the requested period is required for initial authorization.
- An assessment of the family's progress to date including identified barriers if progress is less than expected.
- An anticipated aftercare plan including time frame and suggested aftercare service must be completed at onset of service.
- Duration: 6 months to one year; extensions may be approved up to three months with substantial evidence of progress toward outcomes.

Independent Living Services (Homelessness or Transition)

Description:

Independent Living Support Services (ILSS) is designed to provide a seamless array of services to children that have significant housing needs in addition to needs for case management and training. This service includes necessary efforts to obtain housing, obtain resources for housing, and to maintain housing. Agencies providing this service are expected to be involved in developing and identifying housing options in the community and must be well versed in available housing subsidies and how to advocate for consumers for these resources. Coaching is utilized to develop independent living skills including budgeting, cooking, housekeeping, relationship development skills, leadership skills,

vocational skills and other responsible adult behavior. Additionally, support is provided to assist the young adult in seeking a high school diploma or GED.

Appropriate for:

- Youth, age 16 or older.
- Youth who is Severely and Persistently Mentally Ill (SPMI), **or** SED.
- Youth who has housing support needs such as need for more independent housing, inability to retain current (appropriate) housing, currently in sub-standard housing, inability to coordinate housing resources, etc.
- Youth who meets basic eligibility criteria for case management.
- Youth who is likely to increase independence and use of natural/community resources through use of this service.
- The family is unable to meet the identified need.
- Youth who is in a licensed setting with independent living goals and transition plan in place.

Amount and Duration:

- The ongoing services may be authorized up to one year. Additional services are appropriate only if there is progress toward independence and reduction in paid supports.

Services in Foster Care and Group Home Settings

Description:

Specialized mental health foster care is a range of assistance that enables children to accomplish tasks they would normally do for themselves if they did not have a Serious Emotional Disorder. Care cannot be purchased from legally responsible relatives. Specialized mental health care in these settings, as an additional service, requires that the child have needs that require a more intensive level of care than basic services of a licensed home, of a DSS placement or of a juvenile detention facility. Evidence of this intensity of child need and the family and child centered outcomes addressed must be evident. Permanency planning inherent in this function must address post adoption services (if adoption is part of the permanency plan) that include, therapy for the child around loss and identity or any neglect and abuse issues, parental support, education for the new family regarding child developmental and cultural issues (specifically for international adoptions). The service also includes a focus on shared parenting to address parental fear and control and boundary issues. Education is also provided to caregivers regarding mental illness and substance abuse issues. Specific services may include the following:

- Assistance/support with food preparation, clothing, laundry, and housekeeping beyond the level required by facility licensure (including training in shopping, food preparation, managing laundry, home management which is aimed at increasing the child's ability to manage in a more independent living situation) or contributing to family chores.
- Training in compliance or self administration of medications.
- Health management, including medication management (training and other interventions beyond medication administration) and delegated medical treatments and health management activities.
- Personal relationship establishment/maintenance/opportunities for social activities.
- Leisure activities that are specified in the child and family plan to meet individualized outcomes.
- Promotion of personal/community safety (including behavior management, training in adaptive behaviors, safety training, etc.).

- Increased use and independence in the community, including training in use of community resources.
- Specialized supervision under specific circumstances over and above that required and expected for any foster care setting. Examples include elopement risk supported by recent history and current behaviors indicative and conducive to elopement; consumer at serious risk for harming self or others if unsupervised, supported by recent history and current behaviors indicative of and conducive to this; medical problem that can become life threatening quickly without monitoring due to SED.
- Reunification and transition back to the home.

Appropriate for:

- Child with SED.
- Child must reside in a licensed residential setting.
- Child/family must have a case manager to plan for reunification. The case manager may be from another system.
- Child must display significant deficits in personal care, and/or behavioral control that require ongoing supports above what can be provided in a home setting. Examples are intensive applied behavioral interventions and/or intensive supervision to maintain child's health and/or safety. The Child and Family Plan must detail what will be done to decrease or eliminate the need for personal care service, including efforts to return the child to the home and to seek natural/community supports.
- Child's personal care services must address outcomes specified in the Child and Family Plan. Examples of areas to be addressed may include grief work, coping skills, loss and separation, anger management, peer relations, family strengthening and support for remedial education.
- In home supports are inadequate for meeting the consumer's personal care needs.
- The discharge plan must be completed at admission and the family must be involved in reunification efforts.

Amount and Duration:

- The Child and Family Plan must describe the rationale for enhanced supervision.
- Services that cannot be met in the home or through natural/community resources or basic care as described above include behavior management for unexpected problems, as well as expected problems that are documented in the treatment plan.
- The child must be reasonably expected to move home or to a more independent setting within 6 months. Extensions may be granted up to 3 months for modifications in failed reunification attempts but must incorporate parental involvement, a discharge plan in place or a plan for permanency to be effected within 6-9 months but may be extended in the best interests of the child.
- Children's services are only authorized if all other attempts have failed, there is no other funding source (like DSS) the child must be an imminent danger in the home due to a severe emotional disorder.

Case Management

Description:

Services that will assist children and families in gaining access to needed entitlements, medical, social, educational and other services. Core elements of case management include assessment, development of a child and family

centered plan of service, linking/coordination of services (including network, community and natural support services), re-assessment/follow-up, and monitoring of services to ensure they are provided according to the Child and Family Plan and desired outcomes are achieved. Monitoring of services includes all services in the Plan, which may or may not be provided directly by the assigned case manager. Case managers are also required to find and secure placements for children. Face to face contacts with the enrolled child and family must occur at varying frequencies based on the level of care needed. Case Management is provided to children and families who have an array of services and is required for children in licensed residential settings. Case Management is not the exclusive service defined as Care Coordination. Care Coordination is a limited administrative service provided to children and families who do not require an array of service and who generally do not meet the target population definition. Coordination of care among providers and across agencies is however, a part of the case manager's job.

Appropriate for:

- Child with SED.
- Child needs a variety of natural and community based supports, and/or receives multiple services, needs assistance in coordination of those services, and cannot manage this with their family or independently or through the use of natural and community supports; **and/or**
- Child and family have chronic manifestation of problems with limited success in management of those symptoms; **or**
- Child requires "step down" from a more intensive service such as mental health home based services; **or**
- Child behavior routinely decompensates, resulting in regular need for crisis intervention services; **or**
- Child has financial and/or benefit management problems and requires assistance in managing them; **and**
- Family, natural and community supports are unable to meet the child and family need.

Amount and Duration:

- One year or more as needed.

Wraparound Services

Description:

Wraparound facilitation is the delivery of direct, hands on intensive intervention and family preservation services to families and children. The child (ren) and family must have intensive needs involving multiple community systems and services. Service interventions may include frequent/intensive family contact, assessment, referral and coordination to and between other agencies/service providers, and development/ identification/use of community resources and natural supports. Facilitators function as the primary clinician, coordinating the whole treatment scope and overseeing the case in every aspect including the development of a crisis plan across service domains. The facilitator functions with input from the Child and Family Team. Community/Family Coaches provide specific assistance to children with SED. Services may include all or a portion of the following: participation with the child and/or family in community activities; coordinate with schools, the court system, the police, the public health and health care system, and other agencies; liaison between the child and/or family and needed community resources; providing positive role models; performing related activities as outlined in the Child and Family Plan. Behavior Treatment Plan

implementation may include coaching and assisting parents, emergency response to family crises, and participation with the family and/or child in community activities as defined in the Behavior Treatment Plan. Financial assistance to cover personal emergencies including security deposits, first month rent, assistance paying back rent, utility and moving expenses, up to 14 days of emergency shelter and other housing related emergencies if needed through flexible funding to support needs in the Child and Family Plan. Non-financial assistance including but not limited to assistance with landlord negotiations, locating appropriate housing options, referrals to appropriate community resources, referral to appropriate health and mental health programs and help locating food, clothing, transportation and shelter is also a function of this service.

Appropriate for:

- Child referred is 17 years of age or younger.
- Child has a diagnosis of SED or less severe emotional disorder with significant functional/behavioral/cognitive/medical deficits.
- Child has involvement with multiple community agencies.
- Child has treatment needs that exceed the scope of treatment by other intensive treatment modalities.
- System concerns about parenting exist which require extensive monitoring and training.
- Child has behavioral problems which require close supervision for safety of child/others.
- Behavioral Treatment Plan is in place which requires family training and role modeling for implementation.
- Parents are unable to manage child in the home without assistance.
- Child is at risk for out of home placement.
- Natural and community resources have not been effective in providing support to the family.
- Other natural and community supports and involved agencies agree to participate in the service delivery through a coordinated plan that shares resources.

Amount and Duration:

- 6 months to one year, as needed.
- Typically, this service should be provided one on one with the Child and with the family unit for training and support. This includes behavior management for unexpected problems, as well as expected problems that are documented in the Child and Family plan.
- Intermittent one time expenses.

Family Support Services

Description:

Education and support for families (parents, spouse, siblings, children, relatives and other caregivers) who are caring for, or who regularly interact with, a family member who has a mental illness or serious emotional impairment. Education includes information about disorders and the development, treatment options and regimens, use of medication, and management of crisis situations, etc. Family support can be defined as facilitating access to a contact person, mentor, help line, support group or family advocate to strengthen families through education and skill development. Examples of skills development includes:

- Use of assistive technology.
- Problem solving skills.
- Self care.

- Communication skills.
- Stress and anger management.
- Behavior management plans, including positive reinforcement.
- Client rights.
- Consumer choice.
- Best practices.
- Parent training, including child management skills training.
- Child and Family Team training.
- Advocacy skills.

Appropriate for:

- Family members, caregivers and significant others of children diagnosed with SED.
- Natural/community resources are not adequate to meet the educational need.

Amount and Duration:

- Intermittent, episodic for specific outcomes in the Child and Family Plan.

Respite Care

Description:

Respite care includes services that are provided to children unable to care for themselves on a short-term basis and whose unpaid primary caregiver requires relief. The service should be delivered during the time of day when the caregiver normally provides care. Respite programs can use a variety of methods to achieve the outcome of relief from care-giving including family friends, trained respite workers, foster homes, residential treatment facilities, respite centers, camps, recreational facilities, etc. Respite care, when predictable, should be agreed to and outlined in the Child and Family Plan giving credence to caregiver and consumer choice about the type, amount and duration of respite necessary to prevent more restrictive placement. Active clinical treatment should not be required as a prerequisite for receiving respite care. Respite coordination should be a care coordination service under the AP/LME to enable families to locate providers. Respite services are not intended to substitute for the services of paid support-training staff, crisis stabilization, and crisis residential treatment or out-of-home placement. Services may be provided in the home or out of home but cannot include the costs of room and board. Payment cannot be made to a responsible relative for the care.

Appropriate for:

- Child is living in a private residence with primary caregiver present.
- Child cannot be left unsupervised for more than short periods of time without potential for serious health and/or safety risks.
- Child with SED.
- Primary caregiver needs relief from providing care to prevent more restrictive service or placement.
- Child's needs cannot be met by natural/community resources.

Amount and Duration:

- Services may be requested as needed for short-term periodic needs, or may be requested for longer periods if necessary, such as the hospitalization of the caregiver, etc.
- Respite services are temporary and/or periodic care taking services aimed at providing relief to regular caretakers so that more restrictive placement or services can be avoided.
- Respite is not authorized as a “day care” service to enable parents to work.

School Based and Vocational Services*

Transitional Services For Skill Building

Description:

Skill Building services are designed to assist individuals in acquiring, retaining, and improving self-help, communication, academic and adaptive skills necessary to achieve gainful employment. The service may be school based to increase attendance and functioning in the school environment or Pre-vocational or Supported Employment.

Prevocational services: Prevocational services are aimed at preparing the individual for paid or unpaid employment. It includes teaching such concepts as attending, task completion, problem solving and safety. Prevocational services are provided to people not expected to enter the workforce within one year. Prevocational activities cannot be directed at teaching skills that are specific to a particular job. Person-centered outcomes for prevocational services cannot be employment related. If the consumer is ready for employment related goals and specific job skills, the supported employment requirements in the next paragraph must be met.

Appropriate for:

- Child has a Serious Emotional Disorder or a Severe and Persistent Mental Illness.
- Child with less severe emotional disorder or mental illness when DPI or VR are providing services and coordination is necessary with the mental health system over a two to three year period for transition purposes.
- Consumer is exiting the child system within the next year.
- Consumer would be reasonably able to accept supported employment within 3 months following the mental health transitional service.
- Child has a case manager.
- Natural and/or community supports are not able to meet this need.
- Child has identified work as an outcome in the PCP.

Amount and Duration:

- Prevocational Skill Building cannot include costs of routine supervision that is the responsibility of an employer.
- Prevocational Skill Building cannot pay for subsidies except as provided by the employer (EAP) or through TANF/Work First programs.
- Prevocational Skill Building does not cover the costs of accommodations that the employer is responsible to provide under the ADA.

*Note: Currently services may be provided under the rubric “Day Treatment”. Day Treatment is a setting for service, not a service in and of itself. It is the intent of this service array to promote best practices by implementing services such as MST and Wraparound in the school setting. An additional goal of this service array is to decrease the practice of segregating children with SED from others in any setting; therefore, services can be applied in current Day Treatment settings, but the movement away from these settings to integrated ones should occur.

Supported Employment

Description:

Service is intended to coordinate vocational rehabilitation services to young adult consumers who have physical and/or mental disabilities, which constitute a substantial impediment to employment. Supported Employment is a service that assists individuals, age 16 and older, with a mental illness and/or a mental illness and a co-occurring disorder (SA and DD) to choose, find and keep competitive employment (community jobs paying at least minimum wage). Supported employment staff carry out all related functions including engagement, assessment, job placement, on-going job support and on-going coordination with all other service(s). The service includes intensive involvement of staff working with the individual in the work setting. There is a work skills focus (interviewing, traveling to and from work, time management, getting along with co-workers, and responding to supervision). There is also emphasis on benefits and any accommodations required by the job.

The services are to prepare for, obtain and maintain employment. Covered services should be provided as a joint agency program to include:

- Transportation needs
- Clothing needs
- Equipment needs
- Trade school/training needs
- Vocational testing
- Employer reimbursement of training wages
- Job development
- Job coaching
- Psychological testing
- Other supports as needed

The supported employment program provides the following:

- Competitive employment rather than transitional, temporary, or sheltered;
- Rapid job searches that don't require a participant to complete long evaluations, work adjustment, etc.;
- Jobs tailored to the individual preferences and skills;
- Time unlimited follow along supports such as weekly "check-ins";
- Integration of supported employment and mental health services
- Zero exclusion criteria, that is, no one is screened out because they are not ready for employment.
- There should be a supportive relationship between the provider and the recipient through whom a variety of services may be implemented according to the employment needs of the individual as identified in the vocational plan. These services include assistance in selecting a job, functional evaluation, assistance in finding/securing a job; on the job support, assistance, and training; and counseling about benefits.
- This service focuses on work schedules that are most accommodating for the individuals and coordination with other services that are assisting in other life domains, social or housing opportunities for example. This is a learn-by-doing service that includes regular, in vivo feedback. When there is a specific behavioral or skill deficit, the vocational staff may make referrals to other providers or may seek the consultation of other providers in managing the deficit.

- This service provides on-going support and supervision on the job site and may also include work related supportive interventions outside of the work environment, in coordination with other providers.

Appropriate for:

- Consumer is transitioning to the adult system and has a Serious Emotional Disorder or Mental Illness.
- Consumer has vocational deficits, identified through the person-centered planning process, that can reasonably be supported by the services provided by this program
- Individual verbalizes desire to work;
- Individual has an established pattern of unemployment or sporadic employment;
- Individual requires assistance to obtain employment and/or requires assistance in addition to what is typically available from the employer to maintain competitive employment.
- Consumer need cannot be met by community or natural resources

Amount and Duration:

- Six months to one year based upon needs in the PCP with evidence that progress is being made toward outcomes.

Cognitive Therapies

Multi-Systemic Therapy

Description:

MST is a program designed to enhance the skills of youth and their families who have anti-social, aggressive/violent behaviors; are at risk of out-of-home placement due to delinquency; are adjudicated youth returning from out-of-home placement; are chronic or violent juvenile offenders; and/or are youth with serious emotional disorders involved in the juvenile justice system. MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to youth and their families. Services include: an initial assessment to identify the focus of the MST intervention, individual therapeutic interventions with the youth and family, peer intervention, case management, crisis stabilization, and respite. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. Services are available in-home, at school and in other community settings. MST involves families and other systems such as the school, probation officers, extended families and community connections. This service is a team approach designed to address the identified needs of children and adolescents with significant behavioral problems and who are transitioning from out of home placements or are at risk of out of home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty-four (24) hours a day by staff that will maintain contact and intervene as one organizational unit. This team approach is structured face–to–face therapeutic interventions to provide support and guidance in all areas of

functional domains including adaptive, communication, psychosocial, problem solving, and behavior management. The service promotes the family's capacity to monitor and manage the youth's behavior. This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom youth and family stability, increasing the youth's and family's ability to cope and relate to others, and enhancing the highest level of functioning in the community.

Appropriate for:

- Youth who displays willing misconduct behaviors (e.g. theft, property destruction, assault, truancy; as well as substance use/abuse or juvenile sex offense, when in conjunction with other delinquent behaviors);
- Youth who is at imminent risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent within 30 days of referral;
- Youth who has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

Moral Reconation Therapy

Description:

Moral Reconation Therapy (MRT) is one of the most researched cognitive behavioral therapies showing recidivism reductions from 20-60%.

A Montana school found that 60.2% of potential suspensions and dropouts were prevented through use of MRT. The program addresses: cognitive-behavioral problems, criminal thinking and needs, problem solving and skill building. The service is provided utilizing workbooks with staff specifically trained in the approach, staff that are enthusiastic and understand Antisocial Personality and Conduct Disorder characteristics and includes structured follow-ups. A major problem identified with all treatment approaches for children is that many children and families drop out of treatment. Among families that begin treatment, 40-60 % terminate prematurely. This attrition is attributed to the many risk factors that are associated with conduct problems, such as socioeconomic disadvantage and high parent stress. It is important for clinicians to consider such issues as transportation, childcare for other children, and difficulties encountered in getting the child to come to sessions. Some evidence has also emerged indicating that placement of CD youth (primarily adolescents) together in groups can actually impede improvement. In part, this is based on the peer culture that can develop in such situations, which may actually increase many deviant behaviors such as increased arrest rate and substance use. This is, however, how such youth are often managed in residential, hospital, and corrections settings. MRT has been shown to be an exception to this rule. Groups are actually recommended. MRT is provided in a group therapy format. It is a manualized Cognitive-Behavioral product designed to enhance ego, social, moral and positive behavioral growth in a progressive step-by-step fashion. MRT was developed in 1985 by Little and Robinson through synthesizing Kohlberg's theories of moral development, Erikson's theories of ego and identity development, behavioral conditioning, Maslov's needs hierarchy and Jung's concepts. MRT attempts to change how offenders make decisions and judgments by raising moral reasoning levels. The program needs to move consumers from hedonistic (pleasure vs. pain) reasoning levels to levels where concern for social rules and others become important.

MRT focuses on confrontation of beliefs, attitudes and behaviors; assesses current relationships; reinforces positive behavior and habits; promotes positive identity formation, enhances self-concept, decreases hedonism, develops frustration tolerance and higher stages of moral reasoning. MRT is conducted in a stepwise process which varies in relation to the diagnoses being treated. The MRT model requires staff completes a 32-hour intensive training. The model may utilize non-degreed staff who have received appropriate training.

Appropriate for:

- Youth who is between the ages of 8 and 18.
- Youth who displays willing misconduct behaviors (e.g. theft, property destruction, assault, truancy; as well as substance use/abuse or juvenile sex offense, when in conjunction with other delinquent behaviors).
- Youth who is at imminent risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent within 30 days of referral.
- Youth who have a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

Amount and Duration

- One year with follow-up.

Cognitive Behavioral Therapy

Description:

Psychosocial treatment for ADHD can be conceptualized into two general categories: those treatments aimed at helping the child to control his or her own behavior through cognitive techniques and those that structure the environment to manage contingencies, primarily behavioral techniques. To date, only behavioral interventions have been demonstrated empirically to be effective in controlling ADHD symptoms. These interventions include training parents to implement contingency-management programs in the home; training teachers to manage contingencies in the classroom and communicate with parents, and professionally conducted contingency management programs in either setting. While each of these approaches has been demonstrated repeatedly to be effective none of the psychosocial treatments is as effective as medication alone in control of ADHD symptoms. Also, none of these techniques has yet been consistently demonstrated to add benefit to medication treatment. As some children do not respond adequately to medication or may have intolerable side effects, or the family may be unwilling or unable to use medication to treat ADHD cognitive-behavioral techniques have an important role in the treatment of ADHD. Basically, all cognitive-behavioral behavioral programs involve assessing problematic responses and determining the environmental conditions that elicit and maintain them. Strategies are then developed to produce change in the environment and therefore in the individual's behavior. Parent training typically uses different methods (reading material, group meetings, clinical assistance) to teach parents to use behavioral techniques in the home. Usually parents are taught to give clear instructions, to positively reinforce desired behavior, ignore some behaviors, and use punishment effectively. The most effective of these programs use a combination of written materials, verbal instruction in social learning principles and contingency management, modeling by the clinician, and behavioral rehearsal of specific skills. Families characterized by low socioeconomic status, parental psychopathology, marital conflict and lack of social support network require the most intensive interventions. Most families will benefit from education about ADHD and treatment. Information about

medication, including side effects and importance of maintaining dosing schedules must be included. Cognitive-behavioral therapy approaches describe a treatment protocol which lasts1.5-4 years and includes the following stages: Construction of a working relationship, Symptom management, Correction of thinking errors, Emotional processing and cognitive re-evaluation of the childhood trauma, Termination. Dichotomous thinking (black and white) is the most frequent thinking error. According to Piaget, such thinking is common in children and is distinguished from more nuanced adult thinking. The consumer should be taught to correct dichotomous thinking with structured cognitive approaches. Other thinking errors commonly made include personalization and catastrophizing. They often use egocentric thinking where a standard may apply to others but not them. Trauma processing may occur using a variety of methods aimed at retelling the story and seeking the explanation and development of empathy for the players.

Appropriate for:

- Youth who is between the ages of 8 and 18.
- Youth who displays ADHD symptoms.
- Youth who is at risk of out-of-home placement, school suspension due to ADHD or is currently in out-of-home placement and reunification is imminent within 30 days of referral.
- Youth who has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

Amount and Duration

- Up to 1.5 years with evidence of progress on outcomes at home and in school.

Dialectical Behavioral Therapy (DBT)

Description:

DBT is a manualized product for treatment practice that combines strategies from behavioral, cognitive, and supportive psychotherapies. It must be administered according to the treatment manual and includes concomitant weekly individual and group therapy that is conducted for one year. The individual therapist applies directive, problem-oriented techniques including behavioral skill training, contingency management, cognitive modification, and exposure to emotional cues. These techniques are balanced with supportive help such as reflection, empathy, and acceptance. Behavioral deficits and other factors that interfere with adaptive solutions are explored and remediation prescribed. Both during and between therapy sessions the therapist is actively teaching and reinforcing adaptive behaviors. The therapist withholds any reinforcement for behaviors that need to change. The emphasis is on teaching people how to manage trauma, rather than rescuing them. Treatment should be geared toward restructuring the consumer's interactions and relationship patterns with key family members as one way of reducing self-destructive behaviors. Theoretically, changes in relationships external to the family would follow. One suggestion is to develop a narrative that explains but does not condone the family's behavior. The therapist and consumer discuss the possible nature, effects and causes of the behavior and develop a strategy by which the consumer can overcome the family's resistance. The consumer is then taught to utilize specific techniques to alter patterns. Sessions are one hour weekly. Telephone contact with the therapist between procedures is part of the DBT process. Group therapy sessions are held concomitantly for two and one half hours and follow a psycho educational

format. Groups focus on three main areas: interpersonal skills, distress tolerance and acceptance of reality, and emotional regulation. Group therapists do not accept calls and direct the individual back to the individual DBT therapist.
Marsha Linehan (1991; 1993a; 1993b;1995) who pioneered this treatment as a psychosocial approach to treat Borderline Personality Disorder (BPD) has identified six behavioral patterns in BPD: The interplay of emotional vulnerability, Self-invalidation, Unrelenting crises, Inhibited grieving, Active-passivity, and Apparent competence. These factors contribute to the emotional instability and interpersonal difficulties experienced. Linehan postulates that these factors, if left untreated continue to deteriorate until approximately age 40. DBT subjects have higher GAS scores. During a six-month follow-up they had less para-suicidal behavior, less anger and better social adjustment. During the final six months the sample had fewer psychiatric inpatient days. DBT utilizes treatment goals hierarchically organized as follows:

1. Reduction of para-suicidal and other life threatening behaviors
2. Reductions of behaviors that interfere with the process of therapy
3. Reduction of behaviors that seriously interfere with the quality of life.

DBT is more effective in controlling anger and promoting social adjustment than other community treatments. DBT also reduces therapy attrition, para-suicidal episodes and inpatient days. While the therapy increases stress tolerance and control of maladaptive behavior, studies indicate that general satisfaction and happiness are not reported to increase. The consumers still feel miserable, but they behave better. Studies also suggest one year of treatment is not sufficient for this population. Adherence to the model was directly correlated with outcomes. This model is most appropriate for older adolescents.

Appropriate for:

- Youth who is between the ages of 14 and 18.
- Youth who displays impulsivity, self-harming behavior, threatening, emotional lability.
- Youth who is at imminent risk of out-of-home placement, school expulsion, inpatient care, or is currently in out-of-home placement and reunification is imminent within 30 days of referral.

Amount and Duration

- Up to two years with evidence of progress toward outcomes.

Collaboration with other agencies

Not all service needs for children with SED can be met by mental health system alone. It is envisioned that AP/LMEs will work in collaboration with the juvenile justice system to promote “problem solving” courts to support the envisioned array of services.

Problem Solving Courts

Description:

- Problem Solving Courts are not a service or treatment activity. However, there are a number of activities incorporated in this concept that are critical to a good service array for children and families. The philosophy includes access to a court case manager who can assist in court scheduling and provision of “one family, one judge” and access to a court psychologist. Treatment activity designed to provide alternatives to incarceration when possible for children with emotional disorders is also incorporated. Activities include collaboration and training with local law enforcement agencies, jail or youth home personnel, prosecutor's office, and the court system to better

recognize the needs of persons with serious mental illness or serious emotional disorder. This may occur through a Mental Health Liaison to the courts to provide consistency in services and planning. Additional activities are assessment for appropriate services as an alternative to being charged and incarcerated on misdemeanor or non-violent felony charges; crisis intervention; ongoing supportive therapy; and consultation with the jail/youth home physician, nurse, and staff for those currently incarcerated.

Crosswalk to Current Service Array

It is recognized that funding mechanisms and service definitions for a number of services in the service array are not yet available in North Carolina. The following grid provides a crosswalk of services currently supported through state funding to the proposed service array. The envisioned service array places an emphasis on community-based services provided in the least restrictive setting. This array also promotes flexible services that can be provided in a variety of settings such as the home, school or workplace. Support for families is an integral component of the envisioned array of services.

Current Service Array	Envisioned Service Array
Assertive Community Treatment Team (ACTT)	-
Assertive Outreach	Assertive Outreach
Case Consultation	Family Support
Case Management	Case Management
Case Support	-
Community Based Services (CBS)	Community Support (elements also included in Wraparound, Intensive In-home Services and other services)
Consultation, Education and Primary Prevention	Family Support
Day/Evening Activity	-
Day Treatment	-
Evaluation	Evaluation
Inpatient Hospitalization	Inpatient Hospitalization
Outpatient Treatment	Outpatient Treatment (focusing on specific evidence-based therapies)
Partial Hospitalization	-
Professional Treatment in Facility-Based Crisis Program	Professional Treatment in Facility-Based Crisis Program
PRTF	PRTF
Residential Treatment Level II Family/Program Type	Residential Treatment – nonsecure Family/Program Type (see also Services in Foster Homes and Group Settings)
Residential Treatment Level III	-
Residential Treatment Level IV	-
Respite	Respite
Screening	Screening
Supported Employment	Supported Employment
	New Services Community Support Individual and Group-Child* Crisis Management* Diagnostic Assessment* Family Support Independent Living Services Intensive In-home Services* Multisystemic Therapy* Specialized Diagnostic Evaluation Unit Transitional Services for Skill Building Wraparound Services *Service definitions are currently in development

Training Needs by Service Array

There are areas of the state where the provider supply is limited. The provider system as a whole needs additional training, especially in assessment and diagnoses, and implementation of best practice protocols. Current levels of education and supervision are not adequate to effectively implement the child mental health system envisioned in

this plan. Following is a delineation of the areas in which training will be needed for stakeholders and providers to put the new service array in place.

I - Assessment and Diagnosis
- Training in Evidence-Based Practice and adopted protocols
- Clinical supervision and consistent retraining
- Awareness training for those using assessments
- System for remediation
- Continuing education for providers
- Cultural competency training
- Training other agencies regarding assessments provided
- Training of advocates and parents on what to expect

II - Community Inpatient and Alternatives
- Specific training on diagnostic protocols in crisis stabilization
- Involvement of family members in training
- Training in MH Court Testimony

III - Community Living
- Peer to peer mentoring
- Training to recognize risk factors, early symptoms, prevention and early intervention
- Parent training on competencies
- Training on outcomes and functional goals
- Training regarding crisis plans
- Financial training for wraparound teams
- Training regarding how to form and work with a Child and Family Team
- Training on Child and Family Treatment Planning
- Strength-based training
- Training for other agencies (Wraparound, Child and Family Plans, and Assets)

IV - School-based and Vocational
- Training for school personnel, 1 on 1 specific to kids needs
- School consultations teams/capacity
- Training on rights and self-advocacy in the educational system
- Public education to create a demand for good service
- Training for school personnel around children with high needs in school settings and children served by multiple agencies
- Train families to work with schools
- Train the trainer for community residents
- Build internal competencies within the system
- Training on how to build training and other resources in the community

V - Cognitive Therapy
- Cognitive Therapies specific treatment at AP/LME
- Training must be acceptable for various licensures (CME, CEU, etc.)

Service Priorities for Building Community Capacity

Research indicates that supports to decrease reliance on restrictive care include family support, provider support for the change effort, gate keeping, moving resources to the community level, and a defined community service array. The State Collaborative recognized a need to put in place key services as defined in the service array so that children exiting state hospitals and residential facilities would have the best chance for community integration and to avoid recidivism to those facilities. The Collaborative was

first and foremost very concerned that children have not been getting adequate assessments and diagnoses based on approved criteria to determine the appropriate level of care and the best application of the service array. They further felt that most children currently in state hospitals and intensive residential settings are children for whom other local systems have failed in their individual efforts. Therefore, many of these children would be eligible for wraparound services that incorporate multiple agencies in providing services through the Child and Family Plan. These plans should be in place prior to discharge from a more restrictive setting and include crisis contingency plans. The community inpatient alternatives such as crisis residential were considered important, but a lower priority in the beginning because better diagnosis and assessment, better Child and Family Planning, better services in the home and better collaboration could deflect the need for such services to a large extent. In this prioritization, family support incorporates respite care and consultation as defined in the service array. Also, there is the need is to train case managers to promote and encourage family oriented planning, linking, monitoring and crisis response based on a Child and Family Plan.

Prioritization of Outcomes

There are a number of models that can be used to measure outcomes. A key is to examine what children and families look like when they don't need the mental health system. The following provides a framework for conceptualizing child and family outcomes and child mental health system outcomes.

- Access
  - Assessment and Diagnosis
  - Timeliness
  - Crisis response
- Appropriateness
  - Right place, time and amount of service
- Attractiveness
  - Family satisfaction
  - Cultural competence
- Effectiveness
  - Child functional outcomes related to home, school, contact with DJJDP and DSS.
  - Developmental assets
- Cost
  - Less use of restrictive residential settings

The key measures to be monitored within this framework include the following:

1. The required service array is available in AP/LME provider networks 95% of the time.
2. Written protocols for best practice are adopted, staff trained and supervised in implementation in 95% of AP/LME provider networks.
3. The Division establishes clear guidelines, protocols and timeliness standards for the Child and Family Plan, including the requirement for all relevant agencies to participate in the development of the plan.
4. Flexible funds are available for Child and Family Plans.
5. State hospital and residential dollars are diverted to local care as children are returned to community settings.

6. The child and family are asked what the desired outcomes of service are 95% of the time.
7. Children have a full assessment within 7 days 95% of the time.
8. The Division promulgates rules or policy to govern the elements of local MOAs including no reject/no eject, families as partners, parental support mechanisms, and who pays for the service.
9. Existing funding is maintained or increased through the period of downsizing.
10. AP/LMEs, providers, judges, agencies such as DPI, DSS, PH, DJJDP, the general public, county commissioners and the legislature are trained in the child mental health plan at least three times by 2004.
11. The Division monitors AP/LME compliance with parameters in the child mental health plan.
12. Compliance with protocols is monitored and documented by the AP/LME 80% of the time.
13. Families receive information on the child's condition and qualified providers to allow them to make informed choices in treatment 100% of the time.
14. A standardized layperson screening tool is utilized for screening that may occur at various community sites to facilitate access to mental health services without the family repeating information.
15. Services are provided in the schools upon request 75% of the time.
16. The number of children who are in custody to receive mental health services is reduced by 50%.
17. Children with non-violent crimes are diverted from detention 75% of the time.
18. Customers are satisfied with the AP/LME care coordination/community supports referral capacity at 95%.
19. The AP/LME does needs assessment annually that involves consumers to determine the adequacy of the provider network 100% of the time.
20. Persons with emergent needs are seen face-to-face within one hour 95% of the time.

Family and State and Local Collaborative involvement in monitoring is critical to the credibility of this plan for children. A major part of the North Carolina Reform effort is to support self-direction and advocacy, meaningful family and stakeholder involvement and quality improvement. The Division will use a Plan, Do, Check and Act Model wherein once the Plan is completed and implemented, data will be made widely available to the public on outcomes related to the plan. Families and other stakeholders are integrated in statewide quality improvement committees as well as committees at the local AP/LME level. Efforts will be increased to make participation meaningful through surveys, focus groups, policy-making committees, licensing and site review teams that include families, and key state and local agencies. Families and stakeholders will be taught how to participate in the evaluation process through available training and education. Recommendations will be incorporated in improvement efforts and improvements are then monitored for success.

The Communication Plan

The education of state hospital employees, AP/LMEs, providers, community agencies, the schools, psychiatrists, advocates, and families who have an investment in restrictive care will be critical to implementation of this type of reform. A three-tiered approach to communication will be used:

- Level 1 – Top Down
  - A general overview of the child mental health plan and its components provided by Department heads to their staff and constituents.
- Level 2 – Horizontal
  - Information regarding the plan tailored specifically for professionals to present to other professionals in their field.
- Level 3 – Bottom Up
  - Families providing testimonials and grass roots stories of the importance and success of such reform.

Operationalizing the Child Mental Health Plan

This section provides an overview of the steps the Division of MH/DD/SAS will take during fiscal years 04 and 05 to operationalize the Child Mental Health Plan. During this period the Division will take a series of discrete steps that will lead to the following outcomes:

- **SFY 03/04 Outcomes:** (1) Completion of the 7 critical success factors in the plan based on related principles and corresponding expectations, and (2) development of the essential structures to support the plan including structures for downsizing state facilities and residential placements.

- **SFY 04/05 Intended Outcome:** (1) Transitioning the service delivery from restrictive settings to community based settings through the expansion of the array of community services and supports.

Clear direction and policy is needed before the concepts and principles are embedded in the plan can be put into operation at the state and local level. Some of the major areas include: expansion of community capacity associated with the Olmstead decision and state facility downsizing; facilitating increased collaboration among state and local agencies; reorienting the service delivery system to the value of family preservation/in home care; and providing training and education regarding the intent of the plan.

The major areas of the plan to be operationalized include the following:

- Community Capacity Expansion
- Reducing Reliance on State Institutions and other restrictive modes of care
- Collaboration among Child- Serving Agencies and Families
- Financing and Funding Mechanisms
- Quality Improvement Processes
- Training

A summary of the major tasks to be achieved, by SFY 03/04 quarters, are as follows:

SFY 03/04 1st Quarter (July 1, 2003 through September 30, 2003)

- Finalize and distribute the child mental health plan.

- Develop and implement a public awareness campaign concerning the plan.

- Develop guidelines regarding community collaboratives, and child and family teams which includes mechanisms to address:
  - Capacity,
  - Access,
  - Barriers, and
  - Funding

SFY 03/04 2nd Quarter (October 1, 2003 through December 31, 2004)

- Establish criteria for determining community capacity needs that reflect the age-specific, developmental needs/ levels of care for children ages birth through 18.

- Finalize service definitions and refine community services array.

- Develop performance measures to assess critical success factors, including objective measures and measures of child/family perceptions and satisfaction.

- Develop child/family outcome measures, including functional, behavioral and environmental measures and child/family satisfaction measures.

- Develop rules or policy to govern the elements of Local Collaborative agreements to include:
  - No reject/no eject;
  - Families as partners, parental support mechanisms; and
  - Responsibility for payment of the service.

- Provide training on the Child Mental Health plan to: AP/LMEs, Providers, Judges, local agencies, etc.

SFY 03/04 3rd Quarter (January 1, 2004 through March 31, 2004)

- Develop and disseminate guidelines regarding system of care philosophy, principles and practices, including community collaboratives and child and family teams.

- Develop strategy to fund and support community collaboratives and family involvement.

- Assess the current use and policies governing the use of all public financial resources available for child mental health services to ensure consistency with plan's overall direction.

- Train AP/LME and division staff regarding QI activities around the child mental health plan.

- Train Child and Family Teams regarding use of individual data for PCP goal setting and evaluation.

- Conduct evaluation of children currently served by Whitaker School and state hospital PRTFs.

SFY 03/04 4th Quarter (April 1, 2004 through June 31, 2004)

- AP/LMEs develop and submit plans for expanding array of community based supports and services. Plans are to include:
  - Analysis of needs/gaps.
  - Evidence of collaboration and coordination with child-serving agencies and families.
  - Evidence of consideration of family, community and cultural values in developing service array.
  - Evidence of a process of accessing informal, community and natural supports.

- Promote training and technical assistance in evidence-based practice and outcomes-based accountability for agencies, families, and providers.

- Begin collecting data on performance measures.
- Seek legislative approval to lift restrictions for CTSP funding such that funds can be used for all children receiving mental health services.
- Develop discharge plans for all children at Whitaker School and state hospital PRTFs utilizing Child and Family Teams and Person-Centered Planning principles.
- Incorporate requirements for service array in LME Performance Agreements.
- Establish consistent Levels of Care criteria for state facility placement and out-of-home placement with prior authorization.

SFY 04/05 1st Quarter (July 1, 2004 through September 30, 2004)

- Provide "bridge funding" to AP/LMEs who are to transition children from Whitaker School and state hospital PRTFs to their home community.
- Provide funding to AP/LMEs to support community capacity expansion as described in child mental health plan.

SFY 04/05 2nd Quarter (October 1, 2004 through December 31, 2004)

- Establish analysis and reporting plan, including benchmarks and targets.
- Develop a training, consultation/TA plan using evidence based practices for children and youth psychiatric services.
- Develop a training, consultation/TA plan for child and youth psychological services.
- Begin collecting data on child and family outcomes for children discharged from Whitaker School (pre- and post-discharge and periodically thereafter).
- Conduct evaluations for all children served in Umstead's latency age program.
- Close Whitaker School and PRTFs at Umstead and Dix Hospital.

SFY 04/05 3rd Quarter (January 1, 2005 through March 31, 2005)

- Provide on-going technical assistance to AP/LMEs and local stakeholders regarding implementation of system of care philosophy, principles, and practices including community collaboratives and child and family teams.
- Develop discharge plans for children served by the Umstead Hospital program for latency age children.
- Provide "bridge funding" to AP/LMEs who are to transition children from Umstead Hospital program for latency age children to their home community.

SFY 04/05 4th Quarter (April 1, 2005 through June 31, 2005)

- Establish a plan for prevention, early identification and intervention for children birth through age 18 and transitions into adulthood.
- Develop ways to maximize coordination of funding and resources between agencies at the local level.
- Begin analyzing progress of implementation toward plan goals, using performance data and aggregate child/family outcomes data and plan improvements.
- Close latency age program at Umstead Hospital.
- Conduct evaluations for children and adolescents remaining in state hospitals and in Wright School and EATP to determine appropriateness for discharge to community-based services.

References

Basic system principles, best practices and facts utilized for this plan were selected or summarized from the documents listed below and from those cited in the State Plan 2003. An attempt was made to review the most current research available.

_____, (1998). A Blueprint for Coalition Building. Bazelon Center for Mental Health Law.

_____, (1999). Staying Together: Preventing Custody Relinquishment for Children's Access to Mental Health Services. Bazelon Center for Mental Health Law & Federation of Families for Children's Mental Health.

_____, (2000). Oppositional Defiant Disorder: A Review of the Past 10 Years, Part 1 *Journal of the American Academy of Child & Adolescent Psychiatry*.

_____, (2001). SFY00-01 Annual Report. Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services.

_____, (2002). Problems identified as Facing State & Local Officials. Bazelon Center for Mental Health Law.

_____, (2002). Penetration Rates for Children. *Open Minds.*

_____, (2002). Government Annual "Seal of Approval" Awarded to 25 Prevention Programs. *SAMSHA News Release.*

_____, (October, 2002). Interim Report of the President's New Freedom Commission on Mental Health. New Freedom Commission on Mental Health.

Baving L., Laucht M., Schmidt, M.H. (2000). Oppositional children differ from healthy children in frontal brain activation. *Journal of Abnormal Child Psychology,* 28, 267-75.

Child Welfare League of America (2002). Behavior management: CWLA best practices guidelines. Washington, D.C.

Costello, E.J.; Angold, A.; Burns, B.J.; Erkanli, A.; Stangl, D.K; and Tweed, D.L. (1996). The Great Smokey Mountains Study of youth: Functional impairment and serious emotional disturbance. *Archives of General Psychiatry*, 53(12): 1137-1143.

Fallon, T. (_____) Juvenile Justice & Mental Health. *American Academy of Child & Adolescent Psychiatry*

Krauss, M. W., Gulley, S., Leiter, V., Minihan, P., Sciegaj, M., Wells, N., & Anderson, B. (2000). The Family Partners Project: Report on a National Survey of the Health Care Experiences of Families of Children with Special Health Care Needs. Boston, MA: Brandeis University and Family Voices.

Linehan, M. M. (1993a). Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York: The Guilford

Press.

Linehan, M. M. (1993b). Skills Training Manual for Treating Borderline Personality Disorder. New York: The Guilford Press.

Linehan, M. M., Armstrong, H., Suarez, A. Allmon, D. & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48, 1060-1064.

Linehan, M. M., Oldham, J. & Silk, K. (1995). Dx: Personality disorder-- now what? *Patient Care*, 29(11), 75-83.

Sawyer, M.G., et al., (2000) Mental Health of Young People in Australia: A National Study of Mental Health and Well-Being. Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.

Stroul, B.A. & Friedman, R,M, (1986), A System of Care for Severely Emotionally Disturbed Children and Youth. CASSP Technical Assistance Center, Washington, D.C.

U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health services, National Institutes of Health, National Institute of Mental Health, 1999.

U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Agenda. Washington, D.C.: Department of Health and Human Services, 2000.

Woodruff, D.W., Osher, D., Hoffman, C.C., Gruner, A., King, M.A., Snow, S.T., & McIntire, J.C. (1999). The role of education in systems of care: Effectively serving children with emotional or behavioral disorders. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume III.* Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Appendix
Outcomes to be Monitored

RESOURCES:

- Maintain existing funding while shifting funding from restrictive care to the community and create a flexible pool of funds to be utilized locally for Child and Family Plans. **
- Informal, community and natural supports are accessed before using or simultaneously with the use of public services.
- Communities develop directories and means for accessing community and natural supports. **
- Communities coordinate existing resources/services including Early Childhood services.

- COMMUNICATION:
- Marketing, Education and Training of Families in rights and responsibilities must be done at the local level.
- Early Intervention and Prevention Activity should be funded and promoted.
- Public Health Education includes mental health and parenting education.
- The Legislature, General Public, local officials and key agency staff must be trained to understand the Plan.**

- PARTNERSHIP WITH STAKEHOLDERS:
- Involve the Collaborative in CQI efforts with at least 50% being families.
- Provide training and supports for families to participate in a meaningful way.
- Create other mechanisms for families and other stakeholders to be involved in Monitoring Outcomes.
- Train other stakeholders in the Plan.
- Encourage Community Capacity Building such as Neighborhood Resource Centers, Parent Skills Training carried out in variety of locations (particularly schools), expand community safety nets, address transportation issues, and provide conflict resolution training.
- Work with physicians to provide training and consultation on child psychiatric/medication issues.
- Work with communities to help each child have a medical home.
- Child and family are asked what the desired outcomes of service are.**
- State monitors AP/LME compliance with child and family plan.**
- Needs assessment and adequacy of provider network.**

BEST PRACTICES:

- Define a minimum required statewide set of services with written standards. **
- Implement and monitor a policy for Least Restrictive Care.
- Adopt best practices that include cultural competencies. **
- Conceptualize children holistically.
- Consider family, community and cultural values in establishing the service array.
- Provide training to the AP/LME, providers and families.
- Recruit competent and qualified providers.
- Create policy and criteria for development of the Child and Family Plan (CFCP).**
- Children have a full assessment within 7 days.**
- AP/LMEs monitor provider compliance with best practice protocols.**
- Families receive information on the child's condition and qualified providers to allow informed choice.**

ACCESS:
- Establish convenient locations and monitor timeliness standards. **
- Create one screening application to be used by all agencies.**
- Make the array of services available statewide.
- Establish gate keeping for entry to restrictive care.
- There is a set of required minimum services for consistency statewide.**
- There is specialist availability to assess target populations with high needs.
- There is outreach to schools, courts and children in foster care.**

ACCOUNTABILITY:
- Establish outcome measures and benchmarks.
- Functional outcomes are designed with input from stakeholders.
- Establish process for collecting evaluation data.
- Clarify CQI expectations in contracts and MOAs.

MEMORANDA OF AGREEMENT:
- State Divisions, Departments set policy for collaboration and boundaries.
- All State Contracts and MOAs include the requirement for Collaboratives.
- Local Collaboratives develop agreements.
- Statewide training is provided in development of agreements at the local level.
- All agreements must minimally include continuity of service agreements, no eject/no reject agreements, families as partners, parental support mechanisms, and who pays for the service.**

**Outcomes the Division will monitor on a regular basis.